Michigan Office of Administrative Hearings and Rules
P.O. BOX 30763
LANSING, MI 48909

Date Mailed: November 12, 2025
Docket No.: 25-028297
Case No.: [redacted]
Petitioner: [redacted]

[redacted]

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এটি একটি গুরুত্বপূর্ণ আইনি ডকুমেন্ট। দয়া করে কেউ দস্তাবেজ অনুবাদ করুন।

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这是一份重要的法律文件。请让别人翻译文件。

Ky është një dokument ligjor i rëndësishëm. Ju lutem, kini dikë ta përktheni dokumentin.

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DECISION AND ORDER

This matter is before the Michigan Office of Administrative Hearings and Rules (MOAHR) and the undersigned Administrative Law Judge (ALJ) pursuant to MCL 400.9 and upon a request for hearing filed on behalf of Petitioner [redacted] (Petitioner).

After due notice, a telephone hearing was held on October 22, 2025. [redacted], Petitioner's legal guardian and mother, appeared and testified on Petitioner's behalf. Stacy Coleman, Contractor, appeared and testified on behalf of the Respondent Macomb County Community Mental Health (Respondent).

During the hearing, the following exhibits were admitted into the record without objection:

Petitioner's Exhibits:

Exhibit #1: Letters and Medical Report

Exhibit #2: Written Statement from Petitioner's representative

Respondent's Exhibit:

Exhibit A: Evidence Packet

ISSUE

Did Respondent properly deny Petitioner's request for reauthorization of services in a licensed specialized residential setting?

FINDINGS OF FACT

The ALJ, based upon the competent, material, and substantial evidence on the whole record, finds as material fact:

1. Petitioner is a [redacted] Medicaid beneficiary who has been diagnosed with schizophrenia, a severe brain injury, and dementia. (Exhibit #1, pages 1-2; Exhibit A, page 16).

2. Since July of 2022, Petitioner has been enrolled with and approved for services through Respondent. (Testimony of Respondent's representative).

3. He initially received services in a setting that just provided room and board, but that was determined to be insufficient to meet his needs and he then moved to a licensed specialized residential setting. (Testimony of Respondent's representative).

4. In the licensed specialized residential setting, Petitioner has received personal care services and community living supports at a per diem rate. (Exhibit A, pages 9, 23-24; Testimony of Respondent's representative).

5. His other approved services include targeted case management, medication reviews, medication administration, and a skill-building program. (Exhibit A, pages 23-24; Testimony of Respondent's representative).

6. On October 15, 2024, a person-centered plan (PCP) meeting was held with respect to Petitioner's plan year of October 10, 2024, through October 9, 2025. (Exhibit A, pages 16-29).

7. In the PCP that was developed, one of Petitioner's goals stated:

> **Residential: Per [Legal Guardian]: "I need him to have someone to take care of his daily needs. He needs prompting to do everything. Instead of club house I would hope his living situation would be able to provide him with the peer interactions he needs. Showering, medication help, continued redirection, food preparation, safety supervision in and out of the home. reminders to complete daily task, safety risk at night."**

Exhibit A, page 20

8. Following that meeting and the completion of the PCP, Petitioner's services, including personal care and CLS in a licensed specialized residential setting were reauthorized. (Exhibit A, pages 22-24).

9. However, on June 20, 2025, Respondent sent Petitioner a Notice of Adverse Benefit Determination stating that a subsequent request for reauthorization of services in a licensed specialized residential setting had been partially denied. (Exhibit A, pages 9-15).

10. Specifically, Petitioner's requested services and setting were only approved for the period of May 17, 2025, to July 31, 2025. (Exhibit A, page 9).

11. With respect to the reason for the action, the Notice of Adverse Benefit Determination stated in part:

> Request received for Specialized Residential Services (SRS). The notes in your chart do not support the need for this service. Request approved one time from 5/17/25 to 7/31/25.
>
> * * *
>
> The clinical documentation provided does not establish medical necessity.
>
> The following criteria was used in your case: MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual/Developmental Disability Service and Supports, Medical Necessity Criteria for Community Living Supports and Personal Care in Licensed Specialized Residential Settings.

Exhibit A, page 9

12. On July 1, 2025, Petitioner filed an Internal Appeal with Respondent regarding that decision. (Exhibit A, page 3).

13. On August 8, 2025, Respondent sent Petitioner a Notice of Appeal Denial. (Exhibit A, pages 3-8).

14. With respect to the reason for the denial, the notice stated in part:

> You are asking for Personal Care services and Community Living Support services in a Special Residential home. We looked at the records given. You do not need this much care. You can get help with a reduced amount of care. You have services from a Case Manager, Skill Building and Medication Reviews. Services at the home will remain active until 07/31/25 to help with the transition. Medical necessity is not met, and the denial is upheld.
>
> Reviewed by PREST psychiatrist:

Certified in Psychiatry by the American Board of Psychiatry and Neurology

Certified in Addiction Medicine by the American Board of Preventive Medicine

Exhibit A, page 3

15. On August 13, 2025, received the request for hearing filed by Petitioner's guardian in this matter.

CONCLUSIONS OF LAW

The Medical Assistance Program (MA) is established pursuant to Title XIX of the Social Security Act and is implemented by Title 42 of the Code of Federal Regulations (CFR). It is administered in accordance with state statute, the Social Welfare Act, the Administrative Code, and the State Plan under Title XIX of the Social Security Act Medical Assistance Program:

> Title XIX of the Social Security Act, enacted in 1965, authorizes Federal grants to States for medical assistance to low-income persons who are age 65 or over, blind, disabled, or members of families with dependent children or qualified pregnant women or children. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the individuals or entities that furnish the services.

42 CFR 430.0

> The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

Section 1915(b) of the Social Security Act provides:

> The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this subchapter, may waive such requirements of section 1396a of this title (other than subsection (s) of this section) (other than sections 1396a(a)(15), 1396a(bb), and 1396a(a)(10)(A) of this title insofar as it requires provision of the care and services described in section 1396d(a)(2)(C) of this title) as may be necessary for a State…
>
> *42 USC 1396n(b)*

The State of Michigan has opted to simultaneously utilize the authorities of the 1915(b) and 1915 (c) programs to provide a continuum of services to disabled and/or elderly populations. Under approval from the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (DHHS) operates a section 1915(b) Medicaid Managed Specialty Services and Support program waiver in conjunction with a section 1915(c).

Here, as discussed above, while Petitioner has been receiving CLS and personal care services through Respondent in a licensed specialized residential setting, Respondent has denied the reauthorization of such services and has decided to transition Petitioner to a lower level of care.

With respect to the location and medical necessity of services through Respondent, the applicable version of the Medicaid Provider Manual (MPM) states in part:

> **2.3 LOCATION OF SERVICE [CHANGES MADE 4/1/2025]**
>
> Services may be provided at or through PIHP service sites or contractual provider locations. Unless otherwise noted in this manual, PIHPs are encouraged to provide mental health and developmental disabilities services in integrated locations in the community, including the beneficiary's home, according to individual need and clinical appropriateness. For office or site-based services, the location of primary service providers must be within 60 minutes/60 miles in rural areas, and 30 minutes/30 miles in urban areas, from the beneficiary's residence.

* * *

2.5 MEDICAL NECESSITY CRITERIA

The following medical necessity criteria apply to Medicaid mental health, developmental disabilities, and substance abuse supports and services.

2.5.A. MEDICAL NECESSITY CRITERIA

Mental health, developmental disabilities, and substance abuse services are supports, services, and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; and/or
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; and/or
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; and/or
- Expected to arrest or delay the progression of a mental illness, developmental disability, or substance use disorder; and/or
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve his goals of community inclusion and participation, independence, recovery, or productivity.

2.5.B. DETERMINATION CRITERIA

The determination of a medically necessary support, service or treatment must be:

- Based on information provided by the beneficiary, beneficiary's family, and/or other

individuals (e.g., friends, personal assistants/aides) who know the beneficiary;

- Based on clinical information from the beneficiary's primary care physician or health care professionals with relevant qualifications who have evaluated the beneficiary;

- For beneficiaries with mental illness or developmental disabilities, based on person-centered planning, and for beneficiaries with substance use disorders, individualized treatment planning;

- Made by appropriately trained mental health, developmental disabilities, or substance abuse professionals with sufficient clinical experience;

- Made within federal and state standards for timeliness;

- Sufficient in amount, scope and duration of the service(s) to reasonably achieve its/their purpose; and

- Documented in the individual plan of service.

2.5.C. SUPPORTS, SERVICES AND TREATMENT AUTHORIZED BY THE PIHP

Supports, services, and treatment authorized by the PIHP must be:

- Delivered in accordance with federal and state standards for timeliness in a location that is accessible to the beneficiary;

- Responsive to particular needs of multi-cultural populations and furnished in a culturally relevant manner;

- Responsive to the particular needs of beneficiaries with sensory or mobility impairments and provided with the necessary accommodations;

- Provided in the least restrictive, most integrated setting. Inpatient, licensed residential or other segregated settings shall be used only when less restrictive levels of treatment, service or support have been, for that beneficiary, unsuccessful or cannot be safely provided; and

- Delivered consistent with, where they exist, available research findings, health care practice guidelines, best practices and standards of practice issued by professionally recognized organizations or government agencies.

2.5.D. PIHP DECISIONS

Using criteria for medical necessity, a PIHP may:

- Deny services:

  - that are deemed ineffective for a given condition based upon professionally and scientifically recognized and accepted standards of care;

  - that are experimental or investigational in nature; or

  - for which there exists another appropriate, efficacious, less-restrictive and cost-effective service, setting or support that otherwise satisfies the standards for medically-necessary services; and/or

- Employ various methods to determine amount, scope and duration of services, including prior authorization for certain services, concurrent utilization reviews, centralized assessment and referral, gate-keeping arrangements, protocols, and guidelines.

A PIHP may not deny services based **solely** on preset limits of the cost, amount, scope, and duration of services. Instead, determination of the need for services shall be conducted on an individualized basis.

MPM, April 1, 2025 version
Behavioral Health and Intellectual and
Developmental Disability Supports and Services Chapter
Pages 11, 14-15
(internal highlighting omitted)

Moreover, with respect to personal care in licensed specialized settings and CLS specifically, the applicable version of the MPM also states:

SECTION 11 – PERSONAL CARE IN LICENSED SPECIALIZED RESIDENTIAL SETTINGS

Personal care services are those services provided in accordance with an individual plan of service to assist a beneficiary in performing their own personal daily activities. For children with serious emotional disturbance, personal care services may be provided only in a licensed foster care setting or in a Child Caring Institution (CCI) if it is licensed as a "children's therapeutic group home" as defined in Section 722.111 Sec. 1(f) under Act No. 116 of the Public Acts of 1973, as amended. For children with intellectual/developmental disabilities, services may be provided only in a licensed foster care or CCI setting with a specialized residential program certified by the state. These personal care services are distinctly different from the state plan Home Help program administered by MDHHS.

Personal care services are covered when authorized by a physician or other health care professional in accordance with an individual plan of services and rendered by a qualified person. Supervision of personal care services must be provided by a health care professional who meets the qualifications contained in this chapter.

11.1 SERVICES

Personal care services include assisting the beneficiary to perform the following:

- Assistance with food preparation, clothing and laundry, and housekeeping beyond the level required by facility licensure, (e.g., a beneficiary requires special dietary needs such as pureed food);

- Eating/feeding;

- Toileting;

- Bathing;

- Grooming;

- Dressing;

- Transferring (between bed, chair, wheelchair, and/or stretcher);

- Ambulation; and

- Assistance with self-administered medications.

"Assisting" means staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); or otherwise assists the individual to perform the tasks themself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).

11.2 PROVIDER QUALIFICATIONS

Personal care may be rendered to a Medicaid beneficiary in a Foster Care or CCI setting licensed and certified by the state under the 1987 Michigan Department of Health and Human Services Administrative Rule R330.1801-09 (as amended in 1995). For children birth to 21, personal care may be rendered to a Medicaid beneficiary in a Child Caring Institution setting with a specialized residential program facility licensed by the State for individuals with I/DD under Act No. 116 of the Public Acts of 1973, as amended, and Act No. 258 of the Public Acts of 1974, as amended.

11.3 DOCUMENTATION

The following documentation is required in the beneficiary's file in order for reimbursement to be made:

- An assessment of the beneficiary's need for personal care.

- An individual plan of services that includes the specific personal care services and activities, including the amount, scope and duration to be delivered that is reviewed and approved at least once per year during person-centered planning.

- Documentation of the specific days on which personal care services were delivered consistent with the beneficiary's individual plan of service.

* * *

17.4.A. COMMUNITY LIVING SUPPORTS (CLS)
NOTE: This service is a State Plan EPSDT service when delivered to children birth-21
years.

Community Living Supports (CLS) are used to increase or maintain personal self-sufficiency, facilitating a beneficiary's achievement of their goals of community inclusion and participation, independence or productivity. The supports may be provided in the beneficiary's residence or in community settings (including, but not limited to, libraries, city pools, camps, etc.).

Coverage includes:

- Assisting (that exceeds State Plan for adults), prompting, reminding, cueing, observing, guiding and/or training in the following activities:

  - meal preparation

  - laundry

  - routine, seasonal, and heavy household care and maintenance

  - activities of daily living (e.g., bathing, eating, dressing, personal hygiene)

- shopping for food and other necessities of daily living

CLS services may not supplant services otherwise available to the beneficiary through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973 or State Plan services, e.g., Personal Care (assistance with activities of daily living in a certified specialized residential setting) and Home Help (assistance in the beneficiary's own, unlicensed home with meal preparation, laundry, routine household care and maintenance, activities of daily living and shopping). If such assistance appears to be needed, the beneficiary must request Home Help from MDHHS. CLS may be used for those activities while the beneficiary awaits determination by MDHHS of the amount, scope and duration of Home Help. If the beneficiary requests it, the PIHP case manager or supports coordinator must assist them in requesting Home Help or in filling out and sending a request for Fair Hearing when the beneficiary believes that the MDHHS authorization of amount, scope and duration of Home Help does not appear to reflect the beneficiary's needs based on the findings of the MDHHS assessment.

- CLS staff providing assistance, support and/or training with activities such as:

  - money management

  - non-medical care (not requiring nurse or physician intervention)

  - socialization and relationship building

  - transportation from the beneficiary's residence to community activities, among community activities, and from the community activities back to the beneficiary's residence (transportation to and from medical appointments is excluded)

- participation in regular community activities and recreation opportunities (e.g., attending classes, movies, concerts and events in a park; volunteering; voting)

- attendance at medical appointments

- acquiring or procuring goods, other than those listed under shopping, and non-medical services

- Reminding, observing and/or monitoring of medication administration

- Staff assistance with preserving the health and safety of the beneficiary in order that they may reside or be supported in the most integrated, independent community setting.

CLS may be provided in a licensed specialized residential setting as a complement to, and in conjunction with, State Plan coverage Personal Care in Specialized Residential Settings. Transportation to medical appointments is covered by Medicaid through Medicaid FFS or the Medicaid Health Plan. Payment for CLS services may not be made, directly or indirectly, to responsible relatives (i.e., spouses, or parents of minor children), or guardian of the beneficiary receiving CLS.

CLS assistance with meal preparation, laundry, routine household care and maintenance, activities of daily living and/or shopping may be used to complement Home Help services when the beneficiary's need for this assistance has been officially determined to exceed the allowable parameters. CLS may also be used for those activities while the beneficiary awaits the decision from a Fair Hearing of the appeal of a MDHHS decision. Reminding, observing, guiding, and/or training of these activities are CLS coverages that do not supplant Home Help.

CLS provides support to a beneficiary younger than 18, and the family in the care of their child, while facilitating the beneficiary's independence and integration into the community.

> This service provides skill development related to activities of daily living, such as bathing, eating, dressing, personal hygiene, household chores and safety skills; and skill development to achieve or maintain mobility, sensory-motor, communication, socialization and relationship-building skills, and participation in leisure and community activities. These supports must be provided directly to, or on behalf of, the beneficiary. These supports may serve to reinforce skills or lessons taught in school, therapy, or other settings. For beneficiaries up to age 26 who are enrolled in school, CLS services are not intended to supplant services provided in school or other settings.
>
> *MPM, April 1, 2025 version*
> *Behavioral Health and Intellectual and*
> *Developmental Disability Supports and Services Chapter*
> *Pages 90-91, 151-153*

Here, Respondent denied Petitioner's request for reauthorization of CLS and personal care services in a licensed specialized residential setting pursuant to the above policies and on the basis that the requested setting is not medically necessary for Petitioner.

In appealing that decision, Petitioner bears the burden of proving by a preponderance of the evidence that Respondent erred. Moreover, the undersigned ALJ is limited to reviewing the Respondent's decision in light of the information it had at the time it made the decision.

Given the information that was available and applicable policies in this case, the undersigned ALJ finds that Petitioner has met his burden of proof and that Respondent's decision must therefore be reversed.

Petitioner was approved for the same services and setting at issue in this case in the past and, while that alone is insufficient to reauthorize services, it is notable that the most recent approval was based on the same PCP that Respondent now takes issue with and there is no evidence in the record of any changes or improvements that would warrant a lower level of care.

Similarly, the notices of action issued in this case failed to identify any specific grounds for the change in services and, instead, just generally and unpersuasively stated that Petitioner did not require a higher level of care. Both notices do reference charts, records or clinical documentation, but none was submitted as evidence in this case.

Respondent's representative did note during the hearing that Petitioner does not require hands-on assistance and only needs verbal prompting. However, even if true, Petitioner's current setting for services could still be appropriate as the MPM expressly states that the assistance provided as personal care services in licensed specialized residential setting means "staff performs the personal care tasks for the individual; or performs the tasks along with the individual (i.e., some hands-on); *or otherwise assists the individual to perform the tasks themself by prompting, reminding, or by being in attendance while the beneficiary performs the task(s).* MPM, April 1, 2025, version, Behavioral Health and Intellectual and Developmental Disability Supports and Services Chapter, page 90.

Moreover, in response to Respondent's unsupported decision that appears to contradict its own past findings, Petitioner's representative credibly testified that the current setting for services remains necessary for Petitioner.

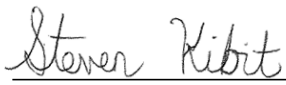
Accordingly, given the whole record, the undersigned ALJ finds that Respondent erred and the decision at issue in this case must be reversed.

DECISION AND ORDER

The Administrative Law Judge, based on the above findings of fact and conclusions of law, decides that Respondent improperly denied Petitioner's request for reauthorization of services in a licensed specialized residential setting.

IT IS THEREFORE ORDERED that:

The Respondent's decision is **REVERSED**.



STEVEN KIBIT
ADMINISTRATIVE LAW JUDGE

APPEAL RIGHTS: Petitioner may appeal this Hearing Decision to the circuit court. Rules for appeals to the circuit court can be found in the Michigan Court Rules (MCR), including MCR 7.101 to MCR 7.123, available at the Michigan Courts website at courts.michigan.gov. The Michigan Office of Administrative Hearings and Rules (MOAHR) cannot provide legal advice, but assistance may be available through the State Bar of Michigan at https://lrs.michbar.org or Michigan Legal Help at https://michiganlegalhelp.org. A copy of the circuit court appeal should be sent to MOAHR. A circuit court appeal may result in a reversal of the Hearing Decision.

Either party who disagrees with this Hearing Decision may also send a written request for a rehearing and/or reconsideration to MOAHR within 30 days of the mailing date of this Hearing Decision. The request should include Petitioner's name, the docket number from page 1 of this Hearing Decision, an explanation of the specific reasons for the request, and any documents supporting the request. The request should be sent to MOAHR

- by email to LARA-MOAHR-DCH@michigan.gov, **OR**
- by fax at (517) 763-0155, **OR**
- by mail addressed to
  Michigan Office of Administrative Hearings and Rules
  Rehearing/Reconsideration Request
  P.O. Box 30639
  Lansing Michigan 48909-8139

Documents sent via email are not secure and can be faxed or mailed to avoid any potential risks. Requests MOAHR receives more than 30 days from the mailing date of this Hearing Decision may be considered untimely and dismissed.

Via Electronic Mail:

Department Contact
BELINDA HAWKS
MDHHS-BPHASA
320 S WALNUT ST 5TH FL
LANSING, MI 48933
MDHHS-BHDDA-HEARING-NOTICES@MICHIGAN.GOV

Petitioner
[redacted]

Respondent
MACOMB COUNTY CMHSP
19800 HALL RD
CLINTON TOWNSHIP, MI 48038
MFHCORRESPONDENCE@MCCMH.NET

Via First Class Mail:

Authorized Hearing Representative
[redacted]